Oral & Maxillofacial Surgery Associates
Pensacola, Florida

Mark. S. Greskovich, D.M.D.
Kevin C. Dean, D.M.D., M.D.

DR. _____

GENERAL INFORMATION

PLEASE PRINT AND ANSWER EACH QUESTION (FOR THE PATIENT) Date:

First Name:	Middle:	Last:	
Sex: ❑ Male ❑ Female	Date of Birth:	Age:	Social Security No.:
Please Check One: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Student			
Patient's Address:	City:	State:	Zip:
Home Telephone No: ( )	Cell Phone No. ( )		
Patient's Occupation:	Employer:		
Employer's Address:	Phone:		
Dentist:	Physician:	Referred by:	
Who will be responsible for this account?	Birthdate:		
Address:	City:	State:	Zip:
Responsible party's Social Security No.	Relation to patient:	Phone:	
First name of Spouse:	Name of Employer:		
If patient is a Minor, first name of Mother:	First name of Father:		
ACCIDENT? ❑ Yes ❑ No If so, Date of Injury:	On Job Injury: ❑ Yes ❑ No		
If Attorney involved, Name:	Phone:		

1- INSURANCE COMPANY (PRIMARY):

Name of Company:	Does your plan cover: ❑ Dental ❑ Medical ❑ Both		
Insured's Name:	Birthdate:	Patient's Relation to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other	
Address of Insurance Co.:	City:	State:	Zip:
Insurance Company's Phone No.: ( )	Policy No.	Group No.	
If insurance is through employer, give the following information:			
Employer's Name:	Occupation:		
Employer's Address:	City:	State:	Zip:

2- INSURANCE COMPANY (SECONDARY):

Name of Company:	Does your plan cover: ❑ Dental ❑ Medical ❑ Both		
Insured's Name:	Birthdate:	Patient's Relation to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other	
Address of Insurance Co.:	City:	State:	Zip:
Insurance Company's Phone No.: ( )	Policy No.	Group No.	
If insurance is through employer, give the following information:			
Employer's Name:	Occupation:		
Employer's Address:	City:	State:	Zip:

PLEASE COMPLETE THE MEDICAL HISTORY ON THE FOLLOWING 2 PAGES

PLEASE CHECK OR INSERT THE CORRECT ANSWER TO THE FOLLOWING QUESTIONS.
ALL WILL BE HELD CONFIDENTIAL.

1. Have you or anyone in your immediate family been a patient of Dr. M. Greskovich, Dr. K. Dean, previously? ☐ Yes ☐ No

If so, please give name of patient: Approximate year when seen:

2. Name of Relative (with whom patient does not reside): Relationship:

Address: Phone:

Name of Friend: Phone:

3. Describe your present problem:

4. When did symptoms first occur?

5. If an accident, please describe:

6. Have you had or have you now any of the following diseases or problems?	YES	NO
(a) Measles, mumps, or chicken pox	☐	☐
(b) Rheumatic fever, or mitral valve prolapse	☐	☐
(c) Congenital heart lesions or heart murmurs	☐	☐
(d) Cardiovascular disease (heart disease, heart attack, coronary occlusion, coronary insufficiency, high blood pressure, stroke, arteriosclerosis, shortness of breath)	☐	☐
(e) Respiratory illnesses, COPD, Sleep Apnea, Tuberculosis, Asthma	☐	☐
(f) Implants placed anywhere in your body (heart valve, hip, knee, etc.)	☐	☐
(g) Diabetes (sugar in the blood)	☐	☐
(h) Hepatitis A or B, jaundice or liver disease	☐	☐
(i) Kidney disease or frequent infections	☐	☐
(j) Inflammatory rheumatism (painful, swollen joints, arthritis)	☐	☐
(k) Allergies, hayfever	☐	☐
(l) Seizures, Epilepsy, ADD/ADHD, Autism, Cerebral Palsy, Asperger's Syndrome	☐	☐
(m) STDs	☐	☐
(n) Abnormal bleeding with previous surgery, extractions, trauma	☐	☐
(o) Acquired Immune Deficiency Syndrome (A.I.D.S.) or A.I.D.S.-Related Disease	☐	☐
(p) Have you ever sought professional care for drug abuse, alcoholism, or emotional disorders?	☐	☐
(q) Illicit or recreational use of drugs (e.g. cocaine, illegal narcotics, sleeping pills, etc.)	☐	☐
(r) Others _____	☐	☐

7. Have you ever been hospitalized or had a serious illness, accident or operation? ☐ ☐

If so, please list with date:

Date	Hospital	Problem

8. Have you had surgery, radiation or chemotherapy for cancer, tumors, growths?	☐	☐
9. Any type of eye surgery within the past 8 weeks?	☐	☐
10. Have you had general anesthesia for surgery?	☐	☐
11. Is there a history of diabetes, coronary disease, cancer or tuberculosis in your immediate family?	☐	☐
12. Amount of smoking per day _____	☐	☐
13. Amount of alcohol per day _____	☐	☐
14. Are you in good health?	☐	☐
Date of last physical examination:		
Are you presently under the care of a physician?	☐	☐
If so, what condition is being treated? _____		
15. Have you had or do you now have hives or skin rash?	☐	☐
16. Do you now have a cold or have you had one within the past week?	☐	☐
(a) Do you have chronic sore throats, sinus trouble, earaches?	☐	☐
17. Do you have glaucoma (eye disease)?	☐	☐

	YES	NO
18. Do you have shortness of breath, chest pain, ankle swelling or require extra pillows when you sleep?	☐	☐
19. Do you have any blood disorders (anemia, etc.)?	☐	☐
20. If female, are you pregnant?	☐	☐
(a) Are your periods regular with normal flow?	☐	☐
21. Do you faint easily?	☐	☐
22. Have you ever had popping or clicking of jaw joint, pain near the ear, difficulty opening mouth?	☐	☐
23. Do you grind or clench your teeth?	☐	☐

24. **Are you allergic to or have reacted adversely to any of the following:**	YES	NO
(a) Local anesthetics (e.g. Novacain)	☐	☐
(b) Penicillin or other antibiotics	☐	☐
(c) Sulfur	☐	☐
(d) Antidepressants, tranquilizers (sleeping pills)	☐	☐
(e) Aspirin, codeine or demerol	☐	☐
(f) Iodine	☐	☐
(g) Any other medicines you are allergic to	☐	☐
(h) Latex	☐	☐

Please list other medications you are allergic to:

25. **Are you taking any of the following?**	YES	NO
(a) Antibiotics or sulfa drugs	☐	☐
(b) Anticoagulants (aspirin, coumadin)	☐	☐
(c) Medicine for high blood pressure	☐	☐
(d) Tranquilizers, antidepressants	☐	☐
(e) Cortisone (steroids)	☐	☐
(f) Insulin, Tolbutamide, Orinase, others	☐	☐
(g) Medicine for seizures	☐	☐
(h) Digitalis (heart medicine)	☐	☐
(i) Nitroglycerin	☐	☐
(j) Birth Control Pills	☐	☐
(k) Diet Pills (Phentermine, etc.)	☐	☐
(l) Herbal medications (echinacea, garlic, ginseng, ginko, kava, ephedra)	☐	☐
(m) Methadone	☐	☐
(n) Any other medicines	☐	☐
(o) Osteoporosis/Bisphosphonates	☐	☐

☐ Fosamax ☐ Boniva ☐ Reclast ☐ Actonel
☐ Didronel ☐ Skelid ☐ Aredia ☐ Zometa

Please list all current medications:

	YES	NO
28. Have you had fluid or foods within the past few hours?	☐	☐
29. Do you have any disease, condition or problem, not listed above, that we should know about or do you have..... anything you need to speak privately to the doctor about? If so, please explain:	☐	☐

I understand the information I provide on this form is essential to determine my dental needs and the provision of treatment and that if any change occurs in my health, I will report it to the office as soon as possible. I have read and understand these questions and answered them all truthfully and to the best of my ability and I have had the opportunity to discuss my health history with the doctor.

I understand that I may be prescribed a narcotic or sedative medication as part of the treatment program for managing my pain. I realize that these medications have potentially serious side effects, including: sedation or drowsiness, confused thinking, possible tolerance, possible addiction.

While taking these medications, I have been told that I should: avoid the use of alcohol, avoid driving or operating hazardous machinery and not make important decisions or sign legal contracts.

I hereby state that I understand the above medical history questionnaire and grant authority to Dr. Mark S. Greskovich, Dr. Kevin C. Dean, ., and/or the doctors in charge of the care of this patient whose name appears above to administer such anesthetics, to perform such operations, and to take such radiographs, as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I also agree I am responsible for payment of this account.

I will be paying today by: ☐ CASH ☐ CHECK ☐ CREDIT CARD

SIGNATURE OF PATIENT OR NEAREST RELATIVE	RELATIONSHIP TO PATIENT	DATE

DR's INITIALS OR SIGNATURE
(to ensure form properly reviewed)

O.M.F.S. CONSULT

NAME _____
DR REQUESTING CONSULTATION _____
CC _____
HPI _____ Ht murmur hx + / − | SBE + / −
PMHX _____
PSHX _____
ALLERGIES _____

MEDS _____

ROS _____

- ☐ ~~Anxiety w/ failure of N2O~~
- ☐ ~~Management & behavior issues~~
- ☐ ~~3 yrs. or less w/ extensive tx~~
- ☐ ~~Infection/cellulitis/abscess present~~

P.E. - EXTRAORAL: _____

INTRAORAL: _____

RADIOGRAPH: _____

DIAGNOSIS: _____

RECOMMENDED TX: _____

RISKS EXPLAINED: PERM. NLTC/LT/ OA FISTULA ___

EXAM TIME: _____

DATE _____
Anesthesia _____ Units ☐1 ☐2 ☐3 ☐4
Impactions: Difficult _____ Full _____
Partial _____ Tissue _____
Deciduous tooth/crown _____
Extraction or exposed root _____

Surg. Rem. Erupted _____

Res. Roots ☐ Sx. _____
Alveo _____ 4+ ext/spaces | UR | UL | _____ 1-3 ext/spaces
W/out _____ 4+ spaces | LR | LL | _____ 1-3 spaces
Osteoma ☐ Maxillary _____ ☐ Mandibular _____
Cyst/Tumor _____ > < 1.25
Lesion _____ ☐ Simple ☐ Complex
RCT-Apico ☐ 1 root ☐ 2 roots ☐ 3 roots _____
Frenuloplasty _____ Frenectomy _____
Exposure _____ w/attachment
I&D _____ ☐ Intraoral / ☐ Extraoral
Biopsy ☐ Exc / ☐ Inc ☐ Soft Tissue / ☐ Bone
Implants _____ ☐ Immediate / ☐ Delay

Graft _____
Fracture _____
Hospital Call _____
Laceration _____
Orthotic (splint) _____
Laser Fee _____ Impressions _____

MG KD JC TS

OG _____

3D CT _____

10 min. _____
20 min. _____
30 min. _____
40 min. _____
50 min. _____
60 min. _____

1. Amoxicillin ..... 500 mg. ..... #21 ..... tid
2. Amoxicillin ..... ☐ 2 grams (4 tabs) ..... P.O. one hour prior
3. Amoxicillin ..... 250 mg. ..... #21 ..... tid
4. Amoxicillin Elixir ..... 250 mg/5cc. ..... 150 cc. ..... 5cc tid
5. Amoxicillin Elixir ..... 125 mg/5cc. ..... 150 cc. ..... 5cc tid
6. Keflex ..... 500 mg. ..... #28 ..... qid
7. PenVK ..... 500 mg. ..... #28 ..... T tab qid
8. Doxycycline ..... 100 mg. ..... #14 ..... bid
9. Zithromax ..... 250 mg. ..... As directed
10. Cleocin ..... 150 mg. ..... #21 ..... tid
11. Cleocin ..... ☐ 600mg (4 tabs) ..... P.O. one hour prior
12. Cleocin Elixir ..... 75 mg/5cc. .... 200 cc. bottle ..... 10cc tid
13. Flagyl ..... 500 mg. ..... #24 ..... tid
14. Augmentin ..... 875 mg. ..... #14 ..... bid
15. Tramadol ..... 50 mg. ..... #20 ..... T q 6 h prn pain
16. Tylenol #3 w/Codeine ..... #20 ..... q 4-6 h prn pain
17. Tylenol Elixir w/Codeine ..... 100cc ..... 5 cc q 3-4 h prn pain
18. Hydrocodone ..... 7.5 mg ..... #20 ☐ Refill #____ .. q 4 h prn pain
19. Hydrocodone elixir ..... 2.5 mg / 5cc ..... 200 cc ..... 10cc q 3-4 h prn pain
20. Demerol ..... 50 mg ..... #20 ..... T po q 6 pm pain
21. Dilaudid ..... 4 mg ..... #20 ..... T po q 6 pm pain
22. Promethazine ..... 25 mg ..... ½ tab po q6 pm nausea/vomiting
23. Zofran ..... 4 mg ..... #_____ q 6 h prn nausea/vomiting
24. Flexeril ..... 10 mg ..... #30 ..... tid
25. Xanax ..... 1.0 mg ..... #_____ q h s-q AM
26. Percocet ..... 7.5 mg / 325 mg ..... #24 ..... q 4-6 h prn pain
27. Peridex ..... 1 Bottle ..... ☐ Refill #____ ..... ½ oz tid
28. Dexamethasone Elixir ..... 0.5mg/5cc/300cc ..... 10cc swish/spit bid
29. Dexamethasone Dose Pack ..... as directed
30. Motrin ..... 600 mg ..... #30 ..... q 6 h prn pain
31. Nystatin .... 100,000 units/ML, 280ML 5ML ..... p.o. swish 5 minutes & spit qid
32. Ultracet ..... 37.5/325mg ..... #20 ..... T-TT q 6 h prn pain